Please **carefully read all of the information in this packet** before completing and presenting your Standard Tort Claim.

**A New Law that Impacts Presenting a Standard Tort Claim Form**

Engrossed Substitute House Bill 1553, effective July 26, 2009, requires citizens to present the Standard Tort Claim form to the agent for a local government entity. In compliance with these requirements and for the convenience of citizens, Clallam County has developed a Standard Tort Claim Form Packet.

**Documents Contained in the Standard Tort Claim Form Packet**

1. Instructions for completing the Standard Tort Claim Form
2. Standard Tort Claim Form
3. Medical Authorization
4. Vehicle Collision Form only for tort claims involving vehicle accidents/collisions

**Legal Requirements for Presenting Standard Tort Claim Forms**

In order to verify the claim and additional supporting information, the law requires that the Standard Tort Claim form be signed by:

- Claimant; or
- Person holding a written power of attorney from the Claimant; or
- Attorney in fact for the Claimant; or
- Attorney admitted to practice in Washington State on the Claimant’s behalf; or
- A court-approved guardian or guardian ad litem on behalf of the Claimant

**Present in Person or Mail the Standard Tort Claim Form and Supporting Documents to:**

Clallam County Auditor  
Clallam County Courthouse  
223 East Fourth Street, Suite 1  
Port Angeles, WA  98362-3015

Business Hours: Monday-Friday, 8:30 a.m. to 4:30 p.m.  
Closed on weekends and County holidays.

July 26, 2009
INSTRUCTIONS FOR COMPLETING
CLALLAM COUNTY STANDARD TORT CLAIM FORM

• Before presenting a Standard Tort Claim form, please read these instructions, the Standard Tort Claim form, and other appropriate forms in their entirety.

• Type or print clearly in ink and sign the Standard Tort Claim form.

• Provide all requested information and any available documents or evidence supporting your claim, such as medical records or bills for personal injuries, photographs, proof of ownership for property damages, receipts for property value, etc.

• If the requested information cannot be supplied in the space provided, please use additional blank sheets so your Standard Tort Claim form can be easily read and understood.

• The following are examples on how to complete the Clallam County Standard Tort Claim Form:
  1. Smith, Karen Michelle
  2. 1234 College Way NW, Apt. 56, Seattle WA 98178
  3. PO Box 910, Seattle WA 98178
  4. Same (or residence at the time of incident)
  5. 206-123-4567
  6. 8:00 a.m., August 9, 2008
  7. If the incident that caused the damages occurred over a period of time, please provide the beginning time and the ending time in item 7
  8. Washington, Thurston, Tumwater, Campus of South Puget Sound Community College, Building number 22
  9. I-5, Southbound, Milepost 109, near the Martin Way Exit
  10. Washington State Department of Transportation, Highway
  11. Smith, Thomas Arthur, 1234 College Way NW, Apt. 56, Seattle WA 98178 (360) 456-3456; Tow Truck Driver, Nisqually Towing
  12. Unknown
  13. List all other witnesses having knowledge of the incident in question, with their names, addresses, and telephone numbers that are not listed within items 11 and 12. Also include a description of their knowledge. For example, if your sister was with you, when the alleged incident occurred, please include her name, address, telephone number, and indicate she witnessed the incident.
  14. Please provide all of your medical providers with their names, address, telephone numbers, and the type of treatment. If you were treated for a personal injury, please include your medical records and bills.
  15. Please describe the incident that resulted in the injury or damages, specifically answering the questions who, what, where, when and why.
  16. If you reported this incident to law enforcement, safety, or security personnel, please provide a copy of the report or contact information to the person you spoke with.
  17. Please provide the dollar amount for your damages, including your time loss, medical costs, property damage loss, etc. This amount should represent your opinion of total compensation.

• If you are presenting a personal injury claim, please sign and attach the Medical Release form.

• If your claim involves a motor vehicle accident, please complete, sign, and attach the Vehicle Collision Form.

July 26, 2009
CLALLAM COUNTY STANDARD TORT CLAIM FORM

Pursuant to Chapter 4.96 RCW, this form is for filing a tort claim against Clallam County. Some of the information requested on this form is required by RCW 4.96.020 and may be subject to public disclosure. Pursuant to the new law, Standard Tort Claim forms cannot be submitted electronically (via e-mail or fax).

PLEASE TYPE OR PRINT IN INK

Mail or deliver

original claim to: Clallam County Auditor
Clallam County Courthouse
223 East Fourth Street, Suite 1
Port Angeles, WA 98362-3015

Business Hours: Mon. – Fri. 8:30 a.m. – 4:30 p.m.
Closes on weekends and County holidays.

CLAIMANT INFORMATION

1. Claimant's name: ____________________________________________________________
   Last name                       First                        Middle                      Date of birth (mm/dd/yyyy)

2. Current residential address: __________________________________________________

3. Mailing address (if different): ______________________________________________

4. Residential address at the time of the incident (if different from current address):
   __________________________________________________________________________

5. Claimant's daytime telephone number: ____________________________ __________________________
   Home                       Business

6. Claimant's e-mail address: ___________________________________________________

INCIDENT INFORMATION

7. Date of the incident: ____________ Time: ______ a.m. ___ p.m. (check one)
   (mm/dd/yyyy)                                                (check one)

8. If the incident occurred over a period of time, date of first and last occurrences:
   from ____________ Time: ______ a.m. ___ p.m. (check one) to ____________ Time:____ a.m. ___ p.m. (check one)
   (mm/dd/yyyy)                                                (mm/dd/yyyy)

9. Location of incident:
   State and county                   City, if applicable                Place where occurred

10. If the incident occurred on a street or highway:

   ____________________________________________________________
   Name of street or highway  Milepost number  At the intersection with or nearest intersecting street

11. State agency or department alleged responsible for damage/injury:

   __________________________________________________________________________

12. Names, addresses and telephone numbers of all persons involved in or witness to this incident:

   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
13. Names, addresses and telephone numbers of all state employees having knowledge about this incident:
____________________________________________________________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________________________________________________________

14. Names, addresses and telephone numbers of all individuals not already identified in #12 and #13 above that have knowledge regarding the liability issues involved in this incident, or knowledge of the Claimant's resulting damages. Please include a brief description as to the nature and extent of each person's knowledge. Attach additional sheets if necessary.
____________________________________________________________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________________________________________________________

15. Describe the cause of the injury or damages. Explain the extent of property loss or medical, physical or mental injuries. Attach additional sheets if necessary.
____________________________________________________________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________________________________________________________

16. Has this incident been reported to law enforcement, safety or security personnel? If so, when and to whom?
____________________________________________________________________________________________________________________________________________________________________

17. Names, addresses and telephone numbers of treating medical providers. Attach copies of all medical reports and billings.
____________________________________________________________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________________________________________________________

18. Please attach documents which support the claim's allegations.

19. I claim damages from Clallam County in the sum of $___________.

This Claim form must be signed by the Claimant, a person holding a written power of attorney from the Claimant, by the attorney in fact for the Claimant, by an attorney admitted to practice in Washington State on the Claimant's behalf, or by a court-approved guardian or guardian ad litem on behalf of the Claimant.

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

__________________________________________________________
Signature of Claimant
July 26, 2009

__________________________________________________________
Date and place (residential address, city and county)
Authorization for Release of Protected Health Information (PHI) to
The Clallam County Human Resources Department (CCHRD)

Name: ________________________________________________________
(Last, First, Middle Initial or Middle Name)

Date of Birth: Month _____ Day ____ Year ______

I hereby authorize disclosure of my protected health information to the CCHRD, for purposes of processing my claim for damages filed with Clallam County.

I understand that by signing this document, I authorize the release of the following information:

- Complete medical record for all services, including history and physical exam; progress notes; x-ray reports; inpatient admissions; operative notes; physical or other therapy; laboratory and other test reports; physician and physician assistant orders; nursing notes; and all other records and references designated by the provider as part of its medical record.

- HIV Test Results and medical information related to HIV testing or treatment

- Psychiatric, mental and behavioral health records, including treatment notes, assessments, testing documents and results, and medical records related to mental health diagnosis and treatment

- Alcohol assessment, testing, referral or treatment records

- All other chemical dependency assessment of treatment records

- Pharmacy prescriptions and reports

- All letters and memos received or sent, including electronic mail, referencing my treatment, Information related to alleged sexual assault or sexually transmitted disease, including test results

- Urgent care, outpatient or other clinic visit information

- Gynecological and/or obstetrical information

- All client records generated for or by governmental programs of which I am a client. Identify the program(s) and agency: _____________________________________________________.

- Financial records related to my care and treatment
I understand the following: (PLEASE READ AND INITIAL ALL STATEMENTS)

_____   I understand that my records are protected under HIPAA/PHI regulations (federal law) and the Washington State Health Care Information Act (RCW 70.02).

_____   I understand that my health information may be subject to re-disclosure by the CCHRD and not protected for purposes of evaluating and investigating the claim I have filed with Clallam County Washington.

_____   I understand that the specific information to be disclosed in my medical record may include information regarding alcohol, drug or other controlled substance use, counseling referrals and/or a history of testing or treatment of acquired immune deficiency syndrome.

_____   I understand that I may revoke this authorization at any time by notifying CCHRD in writing, and that the revocation will be effective as of the date CCHRD receives it. Any records obtained pursuant to this Authorization for Release of PHI prior to the revocation will be deemed authorized by me for release.

_____   I understand that this Authorization for Release will expire 90 days from the date I sign it. I can also authorize a different time frame for this release to be valid. This permission is valid until my claim is resolved or closed by the CCHRD.

A Photostat of this Authorization carries the same authority as the original for purposes of releasing my records to the CCHRD.

Signature of Authorizing Individual:_______________________________________________________

Date of Signature:  __________________ Telephone number:  ___________________________

Witness (where patient is over 13 and signing the release):  ___________________________________

Where the signer is not the subject of the records:

I am authorized to sign this because I am the (attach proof of authority):

☐Parent of minor  ☐Legal Guardian  ☐Personal Representative  ☐Other

To the Provider or Records Custodian:

Please send legible copies of all records to:

Clallam County Human Resources Department
Clallam County Courthouse
223 East Fourth Street, Suite 16
Port Angeles, WA 98362-3015

July 26, 2009
Please attach this form to your standard tort claim form, if the claim involves a vehicle collision.

### Claimant and Incident Information
- **Claimant's Name**: (A separate form must be completed for each claimant)
- **Date of Accident (MM/DD/YYYY)**
- **Time (AM or PM)**
- **Current Street (Residence) Address**: City, State, ZIP
- **(Residence) Street Address for Six Months Prior to Accident**: City, State, ZIP
- **State/County/City (if applicable) where occurred**
- **Street or Hwy**: Milepost No.
- **Intersection or Nearest Street/Road**

### Vehicle Information (Vehicle #1)
- **Year**, **Make**, **Model**, **License Plate No.**
- **Where Can Car Be Seen?**
- **When?**
- **Name of Vehicle Owner**: Address, City
- **Home and Work Phone**
- **Name of Driver**: Address, City
- **Home and Work Phone**
- **Driver's License Number**, **State of Issuance**, **Date of Expiration**

### Describe Damage
- **Estimated Damage**: $[ ]
- **Your Insurance Company and Policy No.**

### Other Vehicle Information (Vehicle #2)
- **Year**, **Make**, **Model**, **License Plate No.**
- **State/Local Agency, If Known**
- **Name of Owner**: Address, City
- **Phone**
- **Name of Driver**: Address, City
- **Phone**

### Other Non-Vehicle Damage
- **Was Other (Non-Vehicle) Property Damaged? If so, describe what type of property was damaged.**
- **Name of Owner**: Address, City
- **Phone**

### Injured Parties
- **Name**: Address, Phone, Injury, Age, Veh1, Veh2, Veh3, Ped, Oth
  - **Home**
  - **Work**

### Witnesses
- **Name (Attach Additional Sheets If Necessary)**: Address, City, Phone
  - **Home**
  - **Work**

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**July 26, 2009**
COMPLETE ALL DETAILS

Describe conduct and circumstances causing injury or damages and explain the extent of medical, physical or mental injuries. Please identify name, address, and telephone number of treating physicians and other medical providers. Please attach property damage estimates and/or all medical bills in support of your claim. If necessary, attach additional pages containing information in this format.

LIGHT CONDITIONS

- DAYLIGHT
- DAWN
- DUSK
- DARK STREET LIGHTS ON
- DARK STREET LIGHTS OFF
- OTHER (SPECIFY)

TRAFFIC CONTROL

- SIGNALS
- STOP SIGN
- LASHING RED
- LASHING AMBER
- RR SIGNAL
- OFFICER/LAGMAN
- YIELD SIGN
- NO TRAFFIC CONTROL
- OTHER

MARK DAMAGED AREAS

- R
- G
- T
- I
- L
- O

VEHICLE CONDITION

- DEFECTIVE BRAKES
- DEFECTIVE HEADLIGHTS
- DEFECTIVE REAR LIGHTS
- TIRES WORN
- PUNCTURED OR BLOWN TIRES
- OTHER (SPECIFY)

ROAD SURFACE

- DRY
- WET
- SNOW
- ICE
- OTHER (SPECIFY)

WEATHER

- CLEAR, CLOUDY & OVERCAST
- RAINING
- SNOWING
- FOG

A separate claim form should be submitted for each claimant.

This information is being provided to aid in resolving the claim.

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

Signature of Claimant  Date and Place (residential address, city and county)